TATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
14/744 P STREET
ACRAMENTO, CA 95814

February 25, 1986

TO: All County Welfare Directors
County Administrative Officers

Letter No.: 86-7

APPLICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL, FORM MC 223 (9/85 REVISION)

Due to recent federal litigation and revisions to Social Security disability regulations, additional information is required in order for the Disability Evaluation Division (DED) to evaluate disability.

As a result, a 15 year vocational history and a social history are required. The MC 223 has been revised (copy attached) to provide the required information and is currently available for order (9/85 revision). Procedures Manual Section 4A has been revised and is being released under separate cover.

The new forms may be ordered by completing the DHS 2031, Forms Order, and sending the order, along with two mailing labels to:

Department of Health Services Warehouse
1723 20th Street
Sacramento, CA 95814

Upon receipt of the new form MC 223 (9/85 rev.) all unused copies of the old MC 223 forms should be destroyed by the county and the new form substituted.

The MC 223 (9/85 rev.) must be in place before May 15, 1986. After that date Disability Evaluation Division (DED) will reject any disability packets containing the old version of the form.

If you experience a delay in obtaining the forms which could result in rejection of disability packages submitted to DED, please contact Toni Bailey at the number provided below as quickly as possible. We will attempt to accommodate special problems, however, we must stress the importance of compliance with Social Security disability regulations.

If you have any questions, please contact Toni Bailey at (916) 324-4953.

Sincerely,

Original signed by

Doris Z. Soderberg, Chief
Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaison
Medi-Cal Program Consultants

Expiration Date: May 30, 1986

LICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL

Original to DED

COUNTY USE ONLY		
County	Aid	Case Number

T STATEMENT OF FACTS

st, Middle, and Last Name

me Address	City	Zip Code

one Number (Check if No Phone [ ]) (Message Phone [ ])	Date of Birth	Social Security Number	4. Height	Weight

Check those conditions that prevent you from working or limit your daily activities.

_____ 1. I have a bone or muscle condition.
_____ 2. I am missing an arm, leg, hand, or foot.
_____ 3. I have trouble seeing, even with glasses or contact lens.
_____ 4. I have trouble hearing, even with a hearing aid.
_____ 5. I have a breathing problem.
_____ 6. I have heart trouble or uncontrolled high blood pressure.
_____ 7. I have diabetes.
_____ 8. I have circulation problems.
_____ 9. I have stomach, intestine, or liver problems.
_____ 10. I have kidney or bladder problems.
_____ 11. I have a blood disease.
_____ 12. I have cancer.
_____ 13. I have mental problems, an emotional illness, or a learning problem.
_____ 14. I have seizures.
_____ 15. I had a stroke.
_____ 16. Other: _____

have had this (these) problem(s) since (month/year) _____

This is how my illness or injury limits my daily activities and affects my ability to work (such as walking, standing, lifting, crawling, ending, stooping, reaching, or handling).

This is my medical treatment record for the last *12 months* starting with my *current treatment*.

Name of Doctors/Clinics/Hospitals	Address	Phone Number	First Seen	Last Seen

A. Have you had any of the following tests in the last year:

TEST	Check Appropriate Block or Blocks Yes	No	If "Yes," Show Where Done	When Done
trocardiogram	☐	☐		
st X-ray	☐	☐		
er X-ray (Name body part here _____)	☐	☐		
thing Tests	☐	☐		
u Tests	☐	☐		
er (Specify) _____	☐	☐		

I have been seen by these agencies because of my disability (for instance, Social Security, Worker's Compensation, etc.)

Name of Agencies	Address	Claim or Case Number	Dates of Visit

The last grade I completed in school was _____ or I passed the GED _____.

finished school or passed the GED in 19 _____ (Year).

The language I speak is [ ] English [ ] Other: _____.

My representative or translator is _____.

His/Her Phone Number: _____ Available During These Days/Hours _____ - _____.

Social History

Describe your daily activities in the following areas and state what and how much you do of each and how often you do it.

* Household maintenance (including cooking, cleaning, shopping, and odd jobs around the house as well as any other similar activities):

* Recreational activities and hobbies (hunting, fishing, bowling, hiking, musical instruments, etc.):

* Social contacts (visits with friends, relatives, neighbors):

* Other (drive car, motorcycle, ride bus, etc.):

☐ I have not worked in the last 15 years. Sign Below.

☐ I have worked in the last 15 years. Sign Below And *COMPLETE PART 2 OF THIS FORM.*

e completed this form correctly and truthfully to the best of my knowledge and abilities.

ure Date

rized Representative Title or Relationship Phone

pleted with

ance of

RT 2 – VOCATIONAL HISTORY

'LICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL
1 Original to DED

COUNTY USE ONLY		
County	Aid	Case Number

irst, Middle and Last Name

ome Address	City	Zip Code

hone Number (Check if No Phone [ ])	Date of Birth	Social Security Number

I have worked in the last 15 years. This is a description of all the jobs I have done for at least 30 days during the last 15 years. I have started with my most recent job. (If you had more than 2 jobs, complete additional pages of this form.)

A. Job Title _____ Type of Business _____

Dates Worked (Month and Year) From _____ To _____

Hours Per Week _____ Rate of Pay _____ Per _____

DESCRIPTION OF THE JOB

is what I did and how I did it.

e are the tools, machines, and equipment I used.

k this long to learn the job _____ days or _____ months

te, completed reports, or performed similar duties. ☐ Yes ☐ No

l supervisory responsibilities ☐ Yes ☐ No

PHYSICAL ACTIVITY

Circle One

ked this many hours a day at work: 0 1 2 3 4 5 6 7 8

d this many hours a day at work: 0 1 2 3 4 5 6 7 8

this many hours a day at work: 0 1 2 3 4 5 6 7 8

bed this much: never _____ occasionally _____ frequently _____ constantly _____

t over this much: never _____ occasionally _____ frequently _____ constantly _____

st weight lifted:

☐ 10 lbs. ☐ 50 lbs.

☐ 20 lbs. ☐ Over 100 lbs.

Weight frequently lifted/carried:

☐ Up to 10 lbs. ☐ Up to 50 lbs.

☐ Up to 20 lbs. ☐ Over 50 lbs.

B. Job Title _____ Type of Business _____

Dates Worked (Month and Year) From _____ To _____

Hours Per Week _____ Rate of Pay _____ Per _____

DESCRIPTION OF THE JOB

This is what I did and how I did it.

These are the tools, machines, and equipment I used.

took this long to learn the job _____ days or _____ months

wrote, completed reports, or performed similar duties. ☐ Yes ☐ No

had supervisory responsibilities ☐ Yes ☐ No

PHYSICAL ACTIVITY

Circle One

Liked this many hours a day at work: 0 1 2 3 4 5 6 7 8

stood this many hours a day at work: 0 1 2 3 4 5 6 7 8

sat this many hours a day at work: 0 1 2 3 4 5 6 7 8

climbed this much: never _____ occasionally _____ frequently _____ constantly _____

bent over this much: never _____ occasionally _____ frequently _____ constantly _____

Heaviest weight lifted:

☐ 10 lbs. ☐ 50 lbs.

☐ 20 lbs. ☐ Over 100 lbs.

Weight frequently lifted/carried:

☐ Up to 10 lbs. ☐ Up to 50 lbs.

☐ Up to 20 lbs. ☐ Over 50 lbs.

☐ I have had other jobs in the last 15 years and have completed another page of vocational history.

I have completed this form correctly and truthfully to the best of my knowledge and abilities.

_____ _____

Signature Date